PRIMARY ADULT CARE PROGRAM
Eligibility Services Division
P.O. BOX 386
BALTIMORE, MD 21203
(TOLL FREE) 1-800-226-2142

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TO BE COMPLETED BY EMPLOYER ONLY.

Dear Employer:

Please supply the following information for:

EMPLOYEE:_____

SOCIAL SECURITY NUMBER:_____

List the Last four (4) Consecutive Pay Stubs Received

Pay Date	**Gross Pay**	**Tips**
	$	
	$	
	$	
	$	

Employee is paid: ☐ Weekly ☐ Bi-Weekly ☐ Monthly
Does the employee receive paid holidays? _____
Does the employee receive paid sick days? _____
Is the employee a seasonal worker? _____ If yes, what is his/her work schedule?_____
If he/she is not currently employed, please indicate last work date. _____
Is the employee permanently terminated? _____
Is the employee on leave? _____ If yes, what is the anticipated date of his/her return?_____
Is the employee eligible for Workman's Compensation, Short Term Disability or Long Term Disability? _____ If yes, who should we contact for more information? _____
If the person has been employed less than one month, indicate the rate of pay and the number of hours per week. _____

Employers Name:_____

Employers Address: _____

Completed By: _____ Title: _____Date:_____